Medicaid Information Bulletin

October 2002

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
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- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

02 - 87 Co-payments for Medicaid / Medicare Clients With QMB Coverage

Bulletin 02 - 58, Copayment Policy Revision, issued July 2002, is modified, effective immediately. The change concerns co-payments for Medicaid/Medicare clients. A Medicaid/Medicare client who has Qualified Medicare Benefits (QMB) is responsible to pay the Medicaid co-payment and co-insurance for two types of Medicaid services: pharmacy and non-emergency use of the emergency room. The Medicaid/QMB client is exempt from all other types of Medicaid co-payments and co-insurance.

Client with Medicare and QMB, but not Medicaid:

Do not collect any co-pay or co-insurance from a client who has Medicare and QMB ONLY; that is, who is not covered by both Medicaid and QMB.

As a reminder, the client's Medicaid Identification Card will state whether or not the client has a co-pay, and if so, for what type(s) of service. For example, the Medicaid/QMB card will state "COPAY/CO-INS FOR: NON EMERGENCY USE OF ER, PHARMACY." Refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 5, Verifying Medicaid Eligibility, for more information on verification of eligibility.

In summary, as of July 1, 2002, Medicaid clients with third party insurance (TPL) or Medicare may have a co-pay. Effective immediately, a Medicaid/QMB client is exempt from Medicaid co-payments and co-insurance, except for pharmacy and non-emergency use of the emergency room. The client continues to be responsible for co-pays for pharmacy and non-emergency use of the emergency room. A Medicare / QMB ONLY client has no co-pay or co-insurance.

SECTION 1, GENERAL INFORMATION, Modified

SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments, sub-heading "Clients Exempt from Co-pay" is updated. Under the statement "A client in one of the following groups does not have a co-pay," remove the line that says "covered by a third party, including Medicare." Add two new lines to the list of exempt clients:

- QMB ONLY [Qualified Medicare Benefits]
- Medicaid/QMB clients, except for pharmacy services and non-emergency use of the emergency room as stated on the Medicaid I.D. Card.

The on-line version of SECTION 1 includes this change. Refer to page numbered 24A dated October 2002. There is a link to the current version of SECTION 1 on the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html

Asterisks in the left margin on page 24A mark where text was removed. A vertical line marks where text was added. If you need a printed copy, please contact Medicaid Information. ☐

02 - 88 Cross-over Claims for Patients with Both Medicare and Medicaid Coverage

On April 1, 2003, the Division of Health Care Financing will begin processing the Medicaid portion of Medicare cross-over claims for patients who have both Medicare and Medicaid coverage. When implemented, providers may contact Medicaid Information concerning the Medicaid portion of cross-over claims, rather than contacting the Medicare Intermediary in Utah (Blue Cross/Blue Shield) as is done now.

Beginning **April 1, 2003**, mail Crossover claims to:

Medicaid Crossovers
PO Box 143106
Salt Lake City, Utah 84114-3106

Provider Manuals Modified

Two sections of the Utah Medicaid Provider Manual are updated to include the new billing address and other information relevant to Crossover claims.

- SECTION 1, GENERAL INFORMATION, Chapter 11 - 7, Filing Crossover Claims, page number 41.
- Utah Medicaid Provider Manual for Hospital Services, SECTION 2, Chapter 5, BILLING, item D, Crossover Claims with EOMB attachment, page 21. Hospital service providers will find this page attached.

There is a link to the current version of SECTION 1 on the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html

A vertical line marks where text was changed. A reminder of this change in billing procedure will be posted on the Medicaid Provider's WHAT S NEW site:

www.health.state.ut.us/medicaid/html/what_s_new.html

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02 - 89 IHC Access Changes to a Preferred Provider Network; Bill Services to Medicaid

When a client's Medicaid card indicates IHC ACCESS as the health plan**, the client must continue to use IHC Access providers** for all services with the exception of optometry, medical supplies and hospice, as well as pharmacy and dental. These services may be rendered by any Medicaid participating provider.

For dates of service on or after October 1, 2002, providers must **submit claims to Medicaid** for reimbursement, not to IHC Access. Providers must follow the Medicaid fee-for-services guidelines for billing, prior authorization, complaints, grievances, etc. [Refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 3, Fee-for-service Medicaid.*] Submit claims electronically, as per SECTION 1, Chapter 11, Billing Claims.

Prior Authorization

When a service for an IHC Access member requires preauthorization, a provider must contact Medicaid, not IHC. [SECTION 1, Chapter 9, Prior Authorization]

Scope of Service is Fee-for-Service

As of October 1, 2002, IHC Access benefits are limited to the Medicaid scope of services. [Refer to SECTION 1, Chapter 3, Fee-for-service Medicaid.] The scope of service allowed under the IHC Access HMO ends September 30, 2002.

Identifying IHC Access Clients

As a reminder, the Medicaid Identification Card states "IHC Access" below eligibility information and above the client's name.

Example of Medicaid Card for IHC Access Updated

The General Attachments Section of the Utah Medicaid Provider Manual has examples of Medical Assistance Identification Cards. A sample IHC Access card sample is on page 7. The text on page 7 dated July 2002 is obsolete for dates of service on or before September 30,

For October 2002, there are three changes to the information on the IHC Access card. First, the word "HMO:" in front of "IHC Access" at the top of the page is removed. The top paragraph includes the information in this bulletin. The telephone number to call for information about medical benefits changed to the number for Medicaid Information.

Also, the IHC Access card sample is moved to page 5, after the Fee-for-service Medicaid Card and before the first HMO card for American Family Care of Utah. Subsequent pages are renumbered.

*SECTION 1 is on-line: There is a link to the current version of SECTION 1 on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. If you need a printed copy, please contact Medicaid Information. ☐

02 - 90 Employment of Sanctioned Individuals

Federal Fraud and Abuse regulations adopted by the Health and Human Services Office of Inspector General in compliance with both HIPPA (Public Law 104-191) and The Balanced Budget Act of 1997 (Public Law 105-33) identify significant civil and criminal actions that may be taken against Medicaid providers who employ federally sanctioned individuals. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Providers need to be aware that it is their responsibility to verify that the individual is not on a federal sanctions list. If a provider does employ an individual who is on the federal sanctions list, and that person provides services which are directly or indirectly reimbursed by a federally funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution and/or exclusion from program participation.

It is essential that providers regularly check the federal sanctions list which can be found at: www.oig.hhs.gov/fraud/exclusions/listofexcluded.html. It would be advisable for all providers to check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization.

If you have a question regarding this information, please call Medicaid Information. Follow the menu prompts to read the Program Integrity Unit, or ask a representative to transfer your call.

SECTION 1 Updated

The information in this bulletin is added to SECTION 1 of the Utah Medicaid Provider Manual as a new Chapter 6 - 18, Employment of Sanctioned Individuals (page 28C). There is a link to the current version of SECTION 1 on the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html ☐

02 - 91 Vagal Neurostimulator for Epilepsy (Criteria #32-A): ICD.9 Codes Added

Two ICD.9 codes which support medical necessity are added to Criteria #32-A, Vagal Neurostimulator for Epilepsy:

345.41 Partial epilepsy, with impairment of consciousness, intractable

345.51 Partial epilepsy, without mention of impairment of consciousness, intractable

These codes are added to the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals. Providers will find attached pages 1 and 27 through 40 to update the list. ☐

02 - 92 Spinal Cord Nerve Stimulation: Neurostimulator Criteria #32-C

Conditions for coverage for a spinal cord neurostimulator are added to the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals. Providers will find attached pages to update the list.

Also, CPT codes 63650 and 63655 are added to the Medical and Surgical Procedure Codes (CPT) with a reference to Criteria #32-C, Spinal Cord Nerve Stimulation. Prior approval is not required. ☐

02 - 93 Helicobacter Pylori: Criteria Added

Criteria for coverage of serologic and stool antigen tests for helicobacter pylori are added to the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals. Providers will find attached pages to update the list.

Also, CPT code 87338 is changed on the Medical and Surgical Procedures list ("CPT Code List") to add a reference to the new Criteria #37, Helicobacter Pylori. CPT code 87339, Infectious agent antigen helicobacter pylori, is non-covered. ☐

02 - 94 Urinalysis, Urine Culture: Criteria Added

Conditions for coverage for a urinalysis or urine culture are added to the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals. Providers will find attached pages to update the list.

Also, two CPT codes are added to the Medical and Surgical Procedures list ("CPT Code List") which refer to Criteria #36,Urinalysis, Urine Culture:

– 87086 Culture, bacterial; quantitative colony count, urine
– 87088 Culture, bacterial; with isolation and presumptive identification of isolates, urine

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Criteria for Medical and Surgical Procedures List On-line

Find this list on-line. Start with the Medicaid Provider's web site:
www.health.state.ut.us/medicaid/html/provider.html

Then use the link to the SECTION 2 list of manuals. On this list there is a link to the Criteria for Medical and Surgical Procedures List On-line.

The direct link to the list is:

www.health.state.ut.us/medicaid/cptcriteria.pdf

If you want a printed copy of the list, use the Medicaid Publications Request Form or contact Medicaid Information. Ask for the October 2002 Criteria for Medical and Surgical Procedures list.

References to UMAP Program Removed from SECTION 1, General Information

The Utah Medical Assistance Program (UMAP) was discontinued June 30, 2002. References to UMAP have been removed from SECTION 1 of the Utah Medicaid Provider Manual. Where appropriate, a reference to the Primary Care Network Program is added. Text changes are marked by a vertical line in the left margin of the page. On-line SECTION 1:

www.health.state.ut.us/medicaid/html/provider.html

02 - 95 Medical Procedures: CPT Codes Covered, Not Covered, or with Limits (62362, 87339, 58953, 58954, 63650, 63655, 87086, 87088, 87338, 92551 - 92596)

The Medical and Surgical Procedures list ("CPT Code List"), an attachment to the Utah Medicaid Provider Manual for Physician Services, is updated. Changes are described below.

Coverage Allowed

CPT code 62362, programmable pump, is covered, so it is removed from the list of restricted CPT codes. (Code 62361, non-programmable pump, continues to be non-covered.)

Added as Non-Covered

CPT code 87339, Infectious agent antigen helicobacter pylori, is added as "NOT A BENEFIT", page 46. Refer to Bulletin 02 - 93, Helicobacter Pylori: Criteria Added.

Prior Authorization Required

Prior Authorization (PA) is required for CPT codes 58953 and 58954, Bilateral salpingo-oophorectomy with omentectomy . . . . PA may be by telephone. Refer to the Criteria for Medical and Surgical Procedures, Criteria #11, Surgical Laparoscopy/Other Medically Necessary Gynecological Procedures. Related ICD.9.CM codes are 65.6 and 65.61. The Hospital Surgical Procedures Codes list, an attachment to both the Physician Services Manual and the Utah Medicaid Provider Manual for Hospital Services, is updated to add the ICD.9 codes which are related to CPT codes 58953 and 58954. Hospital providers will find attached three pages to update this list.

Added With Criteria

The following CPT codes have criteria. The criteria are explained in separate bulletins.

- 63650, Percutaneous implantation of neurostimulator electrode array . . . , and 63655, Laminectomy for implantation of neurostimulator electrodes . . . . Refer to Bulletin 02 - 92, Spinal Cord Nerve Stimulation: Neurostimulator Criteria #32 C.
- 87086 and 87088, Culture, bacterial . . . . Refer to Bulletin 02 - 94, Urinalysis, Urine Culture: Criteria Added.
- 87338, Helicobacter pylori, stool. Refer to Bulletin 02 - 93, Helicobacter Pylori: Criteria Added.
- 92551 through 92596 for audiometry and other hearing tests are limited to Medicaid clients age 20 and younger and pregnant women. Refer to Bulletin 02 - 103, Coverage Limits on Audiology Tests.

Medical and Surgical Procedure Codes (CPT) list Updated

Pages which were updated in either July or in October are attached. If you need a complete, updated copy of the list, please contact Medicaid Information. Ask for the October 2002 Medical and Surgical Procedures list in the Physician's Manual. ☐

02 - 96 Acute Hepatitis Panel, Bundling Codes

CPT code 80074, acute hepatitis panel, includes four other codes: 86709, 86705, 87340, and 86803. When three of the four codes are billed, they will be rebundled into the acute hepatitis panel code 80074 for payment.

Two laboratory-related policy sections are updated to include the statement above: the Utah Medicaid Provider Manual for Physician Services, SECTION 3, Lab Services, and the Utah Medicaid Provider Manual for Laboratory Services, SECTION 2. In both manuals, the addition is a new item C on page 7, under Chapter 2, COVERED SERVICES. Providers will find three pages attached to update lab manuals. The on-line provider manual is also updated. ☐

02 - 97 Physician Assistant Services, Policy Clarified

Bulletin 02 - 65, Physician Assistant Services, issued July 2002 to providers of physician services, did not include all of the updated pages for SECTION 2 of the Utah Medicaid Provider Manual for Physician Services. Providers will find additional pages attached to update SECTION 2. Changes are marked with a vertical line in the left margin.

On page 3, a new number "B", entitled Physician Assistant Services, is added to outline the requirements for Physician Assistant Services consistent with the new practice Rules. On page 4, a definition of "physician Assistant", consistent with federal regulation, is added. On page 4B, a new chapter is added: 1 - 7, Physician Assistant Services: Limitations. On page 5, under Covered Services, the definition of "Personal Supervision by a Physician" is replaced with a new two part definition of "Physician supervision" and "Direct Supervision". ☐

02 - 98 Bill Services for Newborns with Baby's Medicaid I.D. Number

Providers must bill all services for newborns with the baby's own (unique) Medicaid Identification number. Medicaid no longer accepts claims for a newborn billed using the mother's number followed by the letter "B". The baby's identification number can be found on the mother's Medicaid Identification Card, often with the name "Unborn" and the expected date of birth. You may also obtain the baby's Medicaid number by calling Medicaid Information.

If the baby does not have a unique Medicaid Identification number, the mother must notify her Medicaid eligibility worker immediately. The worker determines the child's eligibility, and a unique Medicaid Identification number is assigned to the child.

SECTION 1 Updated

SECTION 1 of the Utah Medicaid Provider Manual, Chapter 11 - 5, Billing Services for Newborns, is revised to remove information about billing claims with a "B" number. On page 41, delete the last three sentences of the second paragraph, beginning with "For 30 days after birth . . . " and ending with "the baby's unique number." The on-line version of SECTION 1 is updated to include this change. An asterisk on page 41 marks where text was removed. There is a link to the current version of SECTION 1 on the Medicaid Provider's web site:
www.health.state.ut.us/medicaid/html/provider.html
If you need a printed copy, contact Medicaid Information. ☐

02 - 99 Correction: Birthing Center Billing Policy

The instructions for billing for services in a Birthing Center have been corrected to remove a reference to billing on a UB-92. The long-standing procedure has been to bill these claims on a HCFA-1500 claim. The correction is in the Utah Medicaid Provider Manual for Hospital Services, SECTION 3, Birthing Center, page 8. If you want a new copy of this section, please contact Medicaid Information. Ask for SECTION 3, Birthing Center Services, in the Hospital Manual, dated October 2002. ☐

02 - 100 Inpatient Hospital, Billing Third Party Claim

SECTION 1, GENERAL INFORMATION, Chapter 11 - 4, Billing Third Parties, states the general policy in regard to patients who have liable third parties such as private insurance, a health maintenance organization, Medicare Part A and B or B only, or Qualified Medicare Benefits (QMB), in addition to Medicaid. However, when a patient with third party insurance receives inpatient hospital services, there are two clarifications to the general information:

1. If the third party pays on the claim, submit the claim to Medicaid and show the TPL amount. TPL includes the insurance payment received plus the related contractual adjustment from the insurer.

2. Payment is limited to patient liability. However, if the adjusted DRG amount from the TPL is less than the patient liability, the adjusted DRG amount is paid. Likewise, Medicare cross-over claims are paid by Medicaid according to the lower of the DRG amount less amounts paid by Medicare and other payers, or the Medicare patient liability (co-insurance and/or deductible).

Hospital Manual Updated

The information in this bulletin is added to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services as a new Chapter 5 - 1, Inpatient Hospital Claims with Third Party Insurance. Hospital providers will find attached a corrected page to update their manuals. A vertical line in the left margin on pages dated October 2002 indicates where text is added. ☐

02 - 101 Increase in Physician Fees

Effective October 1, 2002, the Medicaid Physician Fee Schedule will be increased by an average of 3%. This revision is based on the 1999 Resource-Based Relative Value Scale as utilized by the Health Care Financing Administration for Medicare pricing. CPT codes in the range 70000 - 89999 (laboratory and X-ray codes) are not affected by this adjustment. A revised Medicaid Physician Fee Schedule reflecting these changes can be accessed on the Medicaid Web site [www.health.state.ut.us/medicaid/st_plan/bcrp.htm] or by contacting Randy Baker at (801) 538-6733. ☐

02 - 102 Certified Nurse Midwife Services: DepoProvera C, Progesterone Discontinued

Two medications are discontinued in the Utah Medicaid Provider Manual for Certified Nurse Midwife Services: Y8115, DepoProvera C, and J2675, Progesterone. The codes are removed from page 10 of SECTION 2, Chapter 4, COVERED SERVICES, under the listing Medications and Supplies under the listing Medications and Supplies. Providers will find attached a replacement page to update their manuals. An asterisk on page 10 marks where text was removed.

J2675, Progesterone, was discontinued by HCPCS 2002, effective April 1, 2002, and removed from the approved Injectable Medications List. (Bulletin 02 - 45, Injectable Medication Codes, published April 2002.) Y8115, DepoProvera C, was closed effective July 1, 2000. ☐

02 - 103 Coverage Limits on Audiology Tests

CPT codes 92551 through 92596 for audiometry and other hearing tests are limited to Medicaid clients age 20 and younger and pregnant women. These codes are added to the Medical and Surgical Procedures list ("CPT Code list"), a special attachment to the Utah Medicaid Provider Manual for Physician Services. If you want a complete, printed copy of the current list with CPT codes 92551 through 92596 added, please contact Medicaid Information. Ask for the October 2002 Medical and Surgical Procedures list in the Physician's Manual. ☐

02 - 104 Audiology Program: Codes Added for Hearing Aids

Four new codes for hearing aids are added to the Utah Medicaid Provider Manual for Audiology Services. The codes are:

- V5050, Hearing Aid, monaural, ITE, and V5060, Hearing Aid, monaural, BTE. Both are for global charge. Criteria are the same as for code V5242.
- V5130, Hearing Aid Binaural, ITE, and V5140, Hearing Aid Binaural, BTE, Both are for global charge. Criteria are the same as for code V5248.

Also, descriptors for codes V5242 and V5243 are corrected.

Remember that audiology services are open only to children age 20 and younger and pregnant adults in the Traditional Medicaid program. There are no audiology benefits in Non-Traditional Medicaid nor in the Primary Care Network programs.

Audiology Manual Updated

Providers will find pages attached to update their manual. A vertical line in the left margin on pages dated October 2002 indicates where text has changed. Codes in bold print are newly added to the list. ☐

02 - 105 Podiatry: Limited Services to Adults Restored

On July 1, 2002, all podiatry services were limited to pregnant women and recipients age 20 and younger. However, effective October 1, 2002, certain services will again be covered for all clients. Procedure codes are: 10060; 11000; 11040 - 11044; 11055 - 11057; 11719 - 11721; 11730; 11732; 11750; 17000; 20550; 28120; 28122; 28124; 29425; 29580; 73610; 73620; 73630; 99202; 99212. Refer to the updated pages attached for SECTION 2 of the Utah Medicaid Provider Manual for Podiatry Services.

Also, Chapter 1, PODIATRIC SERVICES, the paragraph titled "Restriction of Services" is revised to read as follows:

"Restriction of Services for Adults

Medicaid covers all podiatric services described in Chapter 8, Reimbursement for Podiatry Services, for children from birth through age 20 and for pregnant women. For dates of service July 1, 2002, through September 30, 2002, Medicaid does NOT cover podiatric services to non-pregnant adults age 21 and older. For dates of service on or after October 1, 2002, Medicaid restored coverage of a limited number of podiatric services to non-pregnant adults age 21 and older."

Co-pay Reminder

As a reminder, podiatry services may require a co-pay. Refer to SECTION 2, Chapter 1 - 3, Co-payment Requirement for Non-pregnant Adults. The first sentence of this chapter is revised to read, "Effective November 1, 2001, many non-pregnant, adult Medicaid clients are required to make a $2.00 co-payment for office visits performed by a podiatrist, when the service is covered by Medicaid." The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. A typical co-payment statement on the Medicaid card will say: " COPAY/CO-INS FOR: NON EMERGENCY USE OF ER, OUTPAT HOSP & PHYSICIAN SVCS, PHARMACY INPAT HOSP." Podiatry services are included as a type of physician service. ☐

02 - 106 Medical Supplies: Codes and Changes

The Medical Supplies List, an attachment to both the Utah Medicaid Provider Manual for Medical Supplies and for Physician Services, is updated. Providers will find attached pages dated October 2002 to update the Medical Supplies List. Changes are described below by type of change, followed by category and page number in the Medical Supplies List:

Discontinued codes and their replacements

A replacement code has the same criteria as the discontinued code.

- Code A4372, Skin barrier, solid 4x4, is discontinued and replaced by A4362, skin barrier, solid 4x4 or equivalent, each. [OSTOMY SUPPLIES, page 7]
- A4373, skin barrier, with flange, is discontinued and replaced by A5123, skin barrier with flange, ... [OSTOMY SUPPLIES, page 8]
- Y5998, Pressure relieving mattress, is discontinued and replaced by E0373, Non-powered advanced pressure relieving mattress. [DECUBITUS CARE, page 25]
- Y6010, Oximeter, . . . is discontinued and replaced by S8105, Oximeter for measuring blood oxygen noninvasively. S8105 is rental only [OXYGEN and RELATED RESPIRATORY EQUIPMENT, page 30]
- Y6083, Flutter Device for CF, is discontinued and replaced by S8185, Flutter device. [OXYGEN and RELATED RESPIRATORY EQUIPMENT, page 30]

Opened codes

The following codes are added to the Medical Supplies List.

- S8490, Insulin Syringe . . . . [SYRINGES, page 8]
- K0549LR, Hospital bed, heavy duty, ... [HOSPITAL BEDS and ACCESSORIES, page 26] Requires telephone prior authorization. Same criteria as E0250.
- L5321, above knee, molded socket, open end, Sach foot, endoskeletal system, single (1 per 5 yrs.) [PROSTHETICS, LOWER LIMB, page 51]

Miscellaneous

- Descriptor revised: A4259, Lancets, per box of 100 [MISCELLANEOUS SUPPLIES, page 9]
- Age limits added to Y6046 and Y6079, as per bulletin 02 - 64, Age Limits on Bathroom Equipment, published July 2002. [BATHROOM EQUIPMENT, pg. 21, issued to physicians in July 2002. Page 21 issued to medical suppliers in October 2002.]

Reminders for the use of E1399

E1399, Durable Medical Equipment, miscellaneous, has required prior authorization since February 21, 2002. Medicaid expects this code to be used for small items (nuts, bolts, brackets, etc.) in the repair of DME and the occasional use for DME items for which there are no HCPCS codes, but which are medically necessary and which will sometimes occur in the CHEC program for children.

This code should not be used for component parts for wheelchairs and as a code for generalized miscellaneous DME use. These situations will require the use of HCPCS codes as listed in the Medicaid Medical Supplies Manual. If there is no code, the item may not be a covered benefit.

This information is added to the Criteria and Instructions column for code E1399, under the category REPAIRS AND DURABLE MEDICAL EQUIPMENT, NOT CLASSIFIED, page 43. ☐

02 - 107 Coding and Coding Guidance Materials

SECTION 1 of the Utah Medicaid Provider Manual is revised to clarify information about coding, as explained in Chapter 8. Coding guidance materials include:

- < Physicians' Current Procedural Terminology (CPT) Manual
- < Healthcare Common Procedure Coding System, HCPCS Level II
- < Healthcare Common Procedure Coding System, HCPCS Level III
- < International Classification of Diseases, 9th Edition, Clinical Modification, (ICD.9.CM), Volumes 1, 2, and 3
- < Revenue Codes (Uniform Billing Codes - UB-92)

Chapter 8 - 1, Healthcare Common Procedure Coding System, is revised, and Chapter 8 - 2 is renamed "Classification Coding".

SECTION 1 Updated

The on-line version of SECTION 1 is updated to include the clarifications on coding, pages numbered 30 and 30A dated October 2002. There is a link to the current version of SECTION 1 on the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html

If you need a printed copy of SECTION 1, please contact Medicaid Information. ☐

02 - 108 Dental Program: Clarifications – Covered Emergency Services – Medicaid Clients in an ICF-MR – Ambulatory Surgical Facilities

Emergency Services for Adults

"Emergency services" means treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

In this context, emergency services consisting of an emergency exam, emergency X-ray, and an emergency extraction service to non-pregnant adults age 21 and older are covered. Examples of services that are not covered under "emergency services" are: a patient complaint that does not meet the definition of an emergency services; chronic conditions without sudden acute symptoms; multiple, serial extractions; teeth that are abscessed, but do not have sudden acute onset of symptoms (pain or swelling).

When the patient requests a non-covered service, the patient may be billed, as long as the requirements for billing non-covered services to Medicaid patients are met. [Utah Medicaid Provider Manual, SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 1, Non-Covered Services]

Medicaid Clients in an ICF-MR

Medicaid dental coverage has not changed for children age 20 and younger residing in an ICF-MR. These services should be billed directly to Medicaid. For adults age 21 and older residing in an ICF-MR, the ICF-MR is responsible to arrange payment for dental services for the client. Do NOT bill Medicaid for dental services for adults age 21 and older residing in an ICF-MR.

Ambulatory Surgical Facilities for Dental Procedures

The limitation on dental services that became effective July 1, 2002, applies only to dental procedures. Same-day surgical benefits for anesthesia are still covered while a dental procedure is done. The dentist is not paid for his services by Medicaid, but the anesthesia and facility costs are paid by Medicaid as part of the medical benefit. All previous prior authorization requirements still need to be obtained prior to rendering services.

Dental Manual Updated

Providers will find pages attached to update the Utah Medicaid Provider Manual for Dental Services. A vertical line in the left margin on pages dated October 2002 indicates where text has changed or been added. ☐

02 - 109 Dental, Orthodontic Services: Fee Increases

Dental Fee Increase

On October 1, 2002, fees for Medicaid dental services will increase substantially. The increase will be about 15% more than the current dental reimbursement.

Orthodontic Fee Increase

On October 1, 2002, Medicaid orthodontic fees increase, and the payment methodology is modified. There will be an initial payment of approximately $2,000 for code D8080 at the time of initial placement of braces. The fee covers the initial placement and adjustment phases of treatment. Upon completion of the case, which is usually 24 months or longer, retention code D8680 may be billed. This payment will be for approximately $200. This change eliminates the quarterly billing and difficulties encountered by eligibility status changes. ☐

02 - 110 Client Information

Several notices have been issued to clients about changes in Medicaid benefits. The subject of each notice is listed below. To read the notices, go to the web site for Medicaid clients:

www.health.state.ut.us/medicaid/html/clients.htm

Look for the listing "**Client Notices, issued July - August 2002**." Subjects are:

- Co-payment change in the Non-Traditional Medicaid program
- Adult Podiatry
- Utah Medical Assistance Program (UMAP) ends
- Primary Care Network (PCN) Program
- Additional notice concerning co-payments
- Medicaid Program Reductions ☐

02 - 111 FREE Vaccines for Children

Did you know that you can receive vaccine at no cost to you for eligible children in your practice? It's true! Participate in the Utah Vaccines for Children (VFC) Program and you will receive free vaccines for eligible children. These include patients 0 through 18 years of age who are: enrolled in Medicaid and CHIP, American Indian or Alaskan Native, have no health insurance, or their insurance does not cover immunizations. Eligible children may receive all childhood recommended vaccines through the Utah VFC Program.

Because the provider can obtain free vaccines through the VFC program, Medicaid will pay only an administration fee. Medicaid will not pay for vaccines available for free to health care providers.

When you participate in the Utah VFC Program, you receive free vaccines and free assessments of the immunization rates in your clinic. A VFC representative will personally visit your clinic to train staff, answer questions about the VFC Program, and offer tips to help you increase your immunization rates.

Enrollment is easy!

Health care professionals who are Medicaid providers should be automatically enrolled in the Utah VFC Program. If you are not enrolled in the Utah VFC Program, call the Utah Immunization Program at (801) 538-9450 and start receiving your free vaccine today! ☐

02 - 112 Immunization Schedule for 2002

The Child Health Evaluation and Care (CHEC) Immunization Schedule is updated to match the U.S. Recommended Childhood Immunization Schedule for 2002. This schedule is included with two Utah Medicaid Provider Manuals:

– CHEC Services manual, Appendix B; and
– Physician Services manual, special attachments, CHEC Immunization Schedule.

The on-line version of the CHEC Immunization Schedule is updated. Use the SECTION 2 link on the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html.

On the SECTION 2 list, use the link to the Immunization Schedule.

If you need a printed copy of the CHEC Immunization Schedule, contact Medicaid Information. ☐

02 - 113 Pediatric Pnemococcal Polysaccharide Vaccine Coverage

The Advisory Committee on Immunization Practices recommends that pneumococcal polysaccharide vaccine be used to prevent pneumococcal pneumonia in high risk children. Eligible children include the following:

1. Children and adolescents aged 2-18 years who have chronic illnesses.
2. Children and adolescents aged 2-18 years who have functional or anatomic asplenia.
3. Children and adolescents aged 2-18 years who are living in special environments or social settings where risk of invasive pneumococcal disease or its complications is increased (e.g. Alaskan natives and certain American Indian populations).
4. Children and adolescents aged 2-18 years who are immunocompromised.

The recommended pneumococcal vaccine schedule is one dose of pneumococcal vaccine for children and adolescents who are at least 2 years of age and at high risk. For children who are immunocompromised or who have functional or anatomic asplenia: If child is aged >10 years, a single revaccination is recommended, if 5 years have elapsed after the previous dose; if the child is 10 years, a single revaccination is recommended 3 years after the previous dose.

The recommended dosage is 1 dose for children and adolescents. The minimum age for first dose is 2 years and the minimum interval from dose 1 to 2 (when applicable) is 3-5 years. For children who are immunocompromised or who have functional or anatomic asplenia: If the child is aged >10 years, a single revaccination is recommended, if 5 years have elapsed after the previous dose; if the child is 10 years, a single revaccination is recommended 3 years after the previous dose.

Contraindications

The following conditions are contraindications to the administration of pneumococcal vaccine:

1. Allergy to vaccine components
2. Acute, moderate or several illnesses with or without fever.

It is prudent on theoretical grounds to avoid vaccinating pregnant women. [1]

The CDC does not have a contract in place for the pneumococcal polysaccharide vaccine so it is not available through Vaccine for Children (VFC) program. State Medicaid programs are required to pay for this

vaccine if given to a child covered by the ACIP recommendation.

Until a contract is in place and pneumococcal polysaccharide is supplied through VFC, Utah's Medicaid program will pay for the administration and vaccine for children to age 5. Pneumococcal polysaccharide vaccine may be billed under CPT code 90732.

Medicaid and the Utah Immunization Program will inform you when the pneumococcal polysaccharide vaccine is available through VFC. ☐

Footnote: [1] www.cdc.nip

02 - 114 'Plan B' No Longer Covered

'Plan B', the day-after birth control product, is no longer covered. The company has not signed a rebate agreement. Please remove the reference to Plan B in the Drug Criteria and Limits list, a special attachment to both the Utah Medicaid Provider Manual for Physician Services and for Pharmacy Services. The reference is on page 3 titled "Drugs with Limits (No Prior Authorization)".

On-line Drug List Updated

The on-line Drug Criteria and Limits is updated to October 2002. An asterisk on page 3 indicates where text was removed. If you need a printed copy, contact Medicaid Information.

To find the on-line list, start with the Medicaid Provider's web site:

www.health.state.ut.us/medicaid/html/provider.html

Then choose the link to the SECTION 2 list of manuals by provider type. Next, on the SECTION 2 list, find the link to the Drug Criteria and Limits list. This list appears under both the pharmacy and the physician manuals. ☐

02 - 115 Diabetic supplies

Diabetic supplies including lancets, strips, and insulin syringes are available through the pharmacy program using 11 digit National Drug Codes. They are also available for medical suppliers who are not pharmacies by using 5 digit medical supplies HCPCS codes. ☐

02 - 116 Health Clinics of Utah Accepting New Patients

Health Clinics of Utah medical clinics are accepting new patients:
- PCN (Primary Care Network)
- All Medicaid HMO's
- Medicaid only
- Medicare
- CHIP
- Private pay

Please use us as a referral source for the insurances listed above that you no longer accept. Health Clinics of Utah have four locations along the Wasatch front with easy access and ample parking:

Salt Lake Health Clinics of Utah
2121 South 230 East
Salt Lake City, Utah 84115
801-468-0354
Open 7:30 to 4:00; Night Clinic 4:00 to 6:30

288 North 1460 West Suite 113
Salt Lake City, Utah 84114
801-538-9424 Call for appointment

Provo Health Clinics of Utah
150 East Center Street Suite 1100
Provo, Utah 84606
801-374-7011 Open: Mon. - Fri. 8:00 to 5:00

Ogden Health Clinics of Utah
2540 Washington Blvd. Suite 122
Ogden, Utah 84401
801-626-3670
Open Mon. - Fri. 8:00 to 5:00
Night Clinic Mon.,Tues., Wed., 4:30 to 6:00

Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing will issue separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. These bulletins are being mailed to enrolled providers. They are also available on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html

The bulletins are under the headings for the Non-Traditional Medicaid Plan and the Primary Care Network. Contact Medicaid Information if you want a printed copy of either bulletin.

02 - 117 Prenatal Vitamins: Documentation Requirement

Prenatal vitamins are covered only for pregnant women. Prenatal vitamins are not covered post-delivery. As part of the pharmacy counseling requirement, the pharmacist must establish the client's due date (month and year) and write it on the prescription. The due date notation will suffice for audit purposes. All prenatal vitamins are reimbursed with a Utah MAC.

The documentation requirement is added to the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, as a new Chapter 5 - 14, Prenatal Vitamins, on page 28. The on-line pharmacy manual is updated as well. In addition, a reminder is added to the Utah Medicaid Provider Manual for Physician Services, SECTION 2, Chapter 3, LIMITATIONS, item DD. which starts "Vitamins may be provided only for: . . . " and continues with "Pregnant women: Prenatal vitamins with 1 mg folic acid." The addition, on page 20, is “Prenatal vitamins are not covered post-delivery.”

Providers will find attached the pages to update their manuals. A vertical line in the left margin on pages dated October 2002 indicates where text was added. ☐

02 - 118 Nursing Facility Resident: Supplemental Purchase of Private Room

The Medicaid per diem payment rate covers routine services and costs associated with a semi-private room. The same per diem rate is paid for a private room if the resident requires a private room due to medical necessity, e.g., communicable infection. In instances where the resident does not require a private room due to medical necessity, it is permissible for residents to use their own funds to supplement the purchase of a private room.

This policy is covered in the Utah Medicaid Provider Manual for Long Term Care Services, SECTION 2, Chapter 4 - 52, Limitations on Charges to Resident Personal Funds, item B # 11: “With written agreement, categories of items and services that the facility may charge to residents’ funds if they are requested and if payment is not made by Medicaid, include: . . . Private room . . . “ ☐

02 - 119 Drug Recycling Program for Medicaid Clients Residing in a LTCF or Nursing Home

Beginning October 1, 2002, the Division of Health Care Financing will partner with selected nursing homes and pharmacies to test a new drug recycling program. The pilot project will last one month. This month long test period will help us refine the operational procedures in preparation of going system wide on November 1, 2002.

This new program is in response to the growing cost of pharmaceuticals. It is possible through the coordinated efforts of the nursing home association, the pharmacies serving nursing homes and the Division of Occupational & Professional Licensing, and the Utah Legislature through a recent change in the law.

Basically, the nursing home will inventory selected, unused drugs at the end of each month, and return them to the pharmacy. The Division of Health Care Financing, in conjunction with the associations, will inform each provider of the program specifics. There will also be a presentation at the Utah Health Care Association conference in September 2002.

Long Term Care Services and Pharmacy Manuals Updated

Information on the new Drug Recycling Program for Medicaid clients residing in a Long Term Care Facility (LTCF) or nursing home is added to both the Utah Medicaid Provider Manual for Long Term Care Services and for Pharmacy Services, SECTION 2.

– In the LTCF manual, the information is placed in a new Chapter 4 - 9, Drug Recycling Program for Medicaid Clients Residing in a LTCF or Nursing Home, page 32.

– In the Pharmacy manual, the information is placed in a Chapter 4 - 5, Drugs for Nursing Home Patients, as a new item 3 after cycle filled prescriptions, on page 8. The on-line pharmacy provider manual is also updated.

Providers will find attached the pages to update their manuals. A vertical line in the left margin on pages dated October 2002 indicates where text was added. ☐